Review of the Investigation Processes Undertaken by Fraser Health Authority and Surrey Memorial Hospital in Response to Concerns Expressed Publicly Regarding Post-Caesarian Section Wound Infections and Head Injury Management

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A. Quality Review

1. Identify Core Components of a Quality Review

The review or investigation of a departure from good practice may initially focus on a specific action or omission of care but a more detailed analysis usually reveals a series of events and departures from safe practice, each influenced by the working environment and the wider organizational context. Structured analysis of incidents is a powerful method of enhancing patient safety and learning about healthcare organizations.

The Canadian Council on Health Services Accreditation requires that facilities have processes for the investigation of critical and other clinical incidents. The Council does not specify which of many structured protocols for the investigation of clinical incidents is used in an institution. Regardless of which protocol is used, it should address the following factors that contribute to deviations from good practice[1]:

<table>
<tr><th>Contributing Factors</th><th colspan="2">Typical Resulting Effects</th></tr>
<tr><td>Institutional context (hospital and health authority)</td><td rowspan="3">Latent Factors</td><td></td></tr>
<tr><td>Organizational and management factors</td><td rowspan="2">Triggering Events</td></tr>
<tr><td>Work environment factors</td></tr>
<tr><td>Team factors</td><td></td></tr>
<tr><td>Individual staff members</td><td></td><td>Unsafe Acts or Omission</td></tr>
<tr><td colspan="3">Individual Patient Factors</td></tr>
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The use of a formal protocol ensures a systematic, comprehensive, and efficient investigation reducing the chance of simplistic explanations and routine assignment of blame. The stages in such investigations should:

a) establish that a serious clinical incident has occurred and ensure it is reported formally;
b) investigate the circumstances as they initially appear and complete a summary, decide which part of the process of care requires investigation, prepare an outline chronology of events, and identify any obvious care management problems;

[1] Vincent C, Taylor-Adams S, Chapman EJ, Hewett D, Prior S, Strange P, Tizzard A. How to investigate and analyse clinical incidents: Clinical Risk Unit and Association of Litigation and Risk Management protocol. BMJ 2000 320: 777-781

c) undertake structured interviews of staff, complainants and medical practitioners to:

- establish chronology of events;
- revisit sequence of events and ask questions about each care management problem identified at the initial stage; and
- use framework to ask supplementary questions about reasons for each care management problem;

d) if new care management problems have emerged during interviews add them to initial list. Interview again if necessary;
e) collate interviews and assemble composite analysis under each care management problem identified. Identify both specific and, where appropriate, general contributory factors;
f) compile report of events, listing causes of care management problems and recommendations to prevent recurrence;
g) submit report to senior clinicians, Management, and the Quality Review Committee, Health Authority Medical Advisory Committee (HAMAC) and Fraser Health Authority Board;
h) implement actions arising from report and monitor progress; and
i) report to complainants if applicable.

2. Review process undertaken by the Fraser Health Authority in the conduct of their review of the patient care complaints to ensure that a comprehensive analysis has been performed and that the core elements have been completed.

2.1 Post-Caesarian Section Surgical Wound Infections

The Issue

In November 2004, nine patients complained publicly about the quality of obstetrical care as reflected by post-caesarian section surgical wound infection at the Surrey Memorial Hospital Family Birthing Unit. I have been asked to review the processes used by the Fraser Health Authority and Surrey Memorial Hospital to investigate and address these complaints.

In total, nine patients came forward either through the press or by self-reporting through an information line made available by the Fraser Health Authority for the reporting of these adverse events.

Surrey Memorial Hospital and Fraser Health Authority Responses

While the public was made aware of the infections occurring in patients in November 2004 through the press, the Family Birthing Unit medical and nursing management were informed of a perceived increase in the post-operative Caesarian section infection rate in the late spring of 2004 by the unit's nursing staff. The infection control team reviewed the concern by analyzing staff communications, medical records, Emergency Department return visit records, and obstetrician incident and microbiology reports. They were not able to confirm a trend but continued monitoring. In late August, monitoring revealed a rising trend and the infection control service launched a formal review that covered the period May 21 through August 31. For this period of time, the infection rate was determined to be 3.57 percent in post caesarian section patients. This is the rate that was made known to the public.

As this post-caesarian section wound infection rate was higher than had been seen previously, further internal investigations were commenced immediately. All infection control practitioners from across Fraser Health Authority were assembled and undertook a comprehensive review of the outcomes of all patients having a caesarian section between April 1 and November 1, 2004. Medical and emergency records were reviewed, as were microbiology reports and obstetrician event reports. The overall infection rate among patients undergoing caesarian section at Surrey Memorial Hospital during this period of time was 2.6 percent. This result is within the range of acceptable practice when all patient and institutional risk factors are considered.

Recognizing that the classification of wound infection, particularly when the assessment is made retrospectively, is subject to interpretive error, Fraser Health Authority organized a review to validate the internal (Fraser Health Authority) infection control practitioners' interpretation of a selection of the wound outcomes for patients treated between April1 and November 1, 2004 and all patients who were reported in the press or who had self reported through the Fraser Health Authority information line. Infection control practitioners from the Provincial Health Services Authority performed the review. Forty-three patient records were reviewed. Both the internal and external reviews agreed on the classification of patients harboring deep wound infection however the internal reviewers classified more patients as having a superficial infection than did the external reviewers. None of the patients classified as having superficial wound infections were subsequently shown to have developed deep surgical site infections.

In addition to confirming the diagnoses of surgical site infection and therefore the rate of infection, Fraser Health Authority undertook an external expert review of infection control procedures and wound surveillance. This review was performed by E. Bryce, MD FRCP in Internal Medicine and Microbiology, Division of Medical Microbiology and Infection Control, Vancouver Hospital and Health Sciences Centre.

In addition, internal and expert external reviews of the medical management of patients by members of the Surrey Memorial Hospital Department of Obstetrics and Gynecology were performed. The internal review included interviews with hospital staff from the Family Birthing Unit, the involved medical practitioners, consenting complainants, and a review of all documentation. Only one complainant chose to participate in this process.

The external review of obstetrical management was performed by V. Frinton, MD FRCSC in Obstetrics and Gynecology and Associate Dean, Faculty of Medicine, University of British Columbia and A. Longhurst, RN, Obstetrics Nurse from St. Paul's Hospital. The review focused on the complainants, with the review team interviewing the majority of women who registered their concerns via the media.

Adequacy of the Review Process

Fraser Health Authority is to be commended in having recognized, in the spring of 2004, a post-operative infection rate that was trending upwards and identified this as a concern. The institution undertook internal and external investigations to verify the trend and to investigate causes prior to when patient complaints were made public. Subsequent analysis of patients operated upon over a longer period of time demonstrated that the upward trend had not continued and that the infection rate remained within acceptable limits.

The congruence of results obtained independently by the internal and external review teams using scientifically validated tools and the trending over a longer period of time confirms that the rate seen in the period May 21 through August 31 was not sustained and not representative of the program's performance. The external review of the hospital's infection control procedures and data analysis confirmed that the rate identified between May 21 and August 31 was not representative. In addition, the review provided recommendations focused on lowering the rate further with the goal of no surgical site infections.

Within the infection control surveillance resources available at the time, the Family Birthing Programme and the Surrey Memorial Hospital were attuned to the possibility of an increasing post-caesarian section infection rate and acted appropriately both before and after the complainants made their issues known. The validation and subsequent investigations were comprehensive in scope and appropriately executed.

The recommendations of the internal and external quality reviews have been received by the Interim Vice President Quality (Fraser Health Authority) and the Local Quality Review Committee for Surrey Memorial Hospital. Many of the recommendations made by the internal and external reviewers have been implemented.

Recommendations – Wound Surveillance and Infection Control

My mandate does not allow access to patient records or to comment upon the care provided to individual patients. The care of individual patients was evaluated by the internal and external reviews. The conclusions drawn by the reviewers regarding the care of individual patients are protected under Section 51 of the *Evidence Act*.

Arising from my review, I make the following observations and recommendations. Approximately, two years ago, the infection control practitioners, previously institutionally based, were centralized within Fraser Health Authority. The goal was to achieve health authority wide infection control standards and decrease considerable variability that existed across the various institutions. As a result, of this realignment and the Fraser Health Authority response to SARS, the active infection surveillance process that had been functional at Surrey Memorial Hospital through ward rounds, chart review, microbiology review, physician and nursing notes, Emergency record review and surgeons reporting was not maintained at the same level as had been the case when the service was hospital based.

Without an infection control team being able to provide surveillance and quality monitoring, the Medical Infection Control Officer was not able to maintain an active role in hospital infection control. During this same period, the Infection Control Committee, a subcommittee of the Surrey Memorial Hospital Medical Advisory Committee, did not report regularly to the Medical Advisory Committee.

The changes in infection control practice were not communicated to clinical teams including the surgical and birthing services, nor where they reported to the Surrey Memorial Hospital Medical Advisory Committee through the Infection Control Committee, with the result that post-operative infection monitoring lapsed until concerns were expressed by the Family Birthing Unit care team late in the spring of 2004.

Recommendation #1: The Medical Advisory Committee and Administration review the subcommittee structure and terms of reference of the Surrey Memorial Hospital Medical Advisory Committee and the Health Authority Medical Advisory Committee to ensure that regular reports of matters required by the Medical Advisory Committee under the health authority bylaws are received and acted upon by the Medical Advisory Committee and are reported to the Fraser Health Authority Board and Administration as required.

An evolving issue shared by Fraser Health Authority, other health authorities and institutions in other jurisdictions is the trend toward increased day care services and shortened hospital stays in the delivery of obstetrical and surgical services. Surgical site surveillance in the outpatient setting is required as post-operative wound infections do not always become apparent during current hospital stays. At the present time, the only ways that infections are recognized and their treatment tracked in the community setting is through physician/surgeon reporting back to the institution or by the infection control team reviewing microbiology and Emergency Department reports.

Recommendation #2: In addition to mandatory reporting of post-operative infections by surgeons and family physicians, a community surgical wound follow-up process should be developed to ensure adequate recognition and tracking of surgical site infections. Community health nurses, BC Nurse Line, or active surveillance by infection control practitioners are options that should be evaluated. In the case of obstetrical infections, the British Columbia Reproductive Care Program should include this information in their patient documentation.

The members of the Surrey Memorial Hospital Department of Obstetrics & Gynecology vary in their clinical practice. Prophylactic antibiotics are not consistently administered in a fashion to decrease surgical site infections. Due to the number of patients requiring obstetrical care in the Family Birthing Unit, it is common for patients to be discharged without a post operative visit by their operating obstetrician. Patients may not be seen following discharge. The volume of patients requiring operative delivery also requires that the practitioners be highly efficient technical surgeons.

Recommendation #3: Departmental policies be implemented ensuring the administration of antibiotics and appropriate skin preparation for elective and emergency Caesarian sections. The workload of practitioners should be reviewed from the perspective of maintaining excellent intraoperative and post-operative care. Where patient volumes exceed the ability of providers to ensure individual patient quality care, additional obstetricians should be recruited. If this is not possible, other providers such as advanced practice nurse practitioners, other medical or midwifery practitioners or clinical associates should be incorporated into the care team to provide post-operative patient assessments. Compensation incentives and disincentives should be addressed.

In support of family centered care, the Family Birthing Unit has permitted partners to be present during delivery. As a result, there can be significant person traffic in and out of the theater during operative deliveries.

Recommendation #4: Policies be developed and implemented that limit visitors and flow through in the Family Birthing Unit Operating Theatre.

Pre and perinatal documentation by all disciplines was reviewed by both the internal and external reviewers. The reviewers have reported that it is difficult to determine the course of clinical care and subsequent complications from the clinical documentation. Wound descriptions were difficult to interpret or were not recorded.

Recommendation #5: The Family Birthing Unit care team review their clinical documentation and to ensure that it provides an accurate record of the care provided and the outcomes for patients.

One of the issues that has been brought to the public's attention was the issue of room cleaning. Fraser Health Authority has established a process for evaluation of cleaning services that was established prior to the changes in cleaning service providers. This process requires the monthly inspection of 650 sites in the health authority. Cleanliness is measured using a United Kingdom validated tool and the inspections are random and unannounced.

The analyses of the Family Birthing Unit, its patient care rooms and the Operating Theater consistently grade in excess of the 80 percent standard required of current cleaning providers. This level of performance has been maintained and has improved since the evaluations were started.

Recommendation #6: All high and very high risk areas should be reviewed for cleanliness on a regular basis.

2.2 Head Injury Management

The Issue

In November of 2004, a family made public their concerns regarding medical services provided in the Surrey Memorial Hospital Emergency Department to a family member who had had a fall from a bicycle. This patient was evaluated in the Surrey Memorial Hospital Emergency Department, was subsequently discharged, only to be re-admitted two days later at which time an intracranial injury requiring surgical intervention was found. It then took several days to affect a transfer to a neurosurgical facility for his treatment. I have been charged to review the processes used by the Fraser Health Authority and Surrey Memorial Hospital to investigate and address this complaint.

Observations of the Emergency Department

The Surrey Memorial Hospital Emergency Department is one of the busiest Emergency Departments in the country seeing 72,000 + visits annually. The facility is challenged by volume of patients, a socially, economically and ethnically diverse patient population and limitations of space and in-patient bed capacity. In the order of 40 percent of the patients wait more than six hours in the department after a medical decision is made to admit. Patients most commonly transferred from the Department to another facility are those with neurological or cardiovascular disorders or with multiple injuries.

Fraser Health Authority provides 60 percent of elective neurosurgical care for the health authority at Royal Columbian Hospital, but only provides 18 percent of acute neurosurgical care within the health authority; all other patients are transferred to Vancouver Coastal Health Authority or Provincial Health Services Authority.

There are no guidelines in current use in the Department for the management of the inebriated patient or the head injured; there is no pre-discharge review of patients who have been kept in the Emergency Department for observation and who are subsequently discharged. There is no physician handover policy at shift change.

There is no process for auditing changes in the condition of patients who are waiting for prolonged periods to be seen, nor is there follow-up of patients who discharge against medical advice or leave the department without being seen.

Because of the high occupancy rate of alternate level of care patients within the hospital, flow-through in the Emergency Department is limited and commonly curtailed. These factors, combined with the design of the physical space and waiting areas conspire to challenge optimal patient care.

Medical and nursing personnel recognize the challenges they face but find it hard to meet the patient care demands and focus on the quality of care they provide.

Adequacy of the Review Process

Fraser Health Authority organized an internal review undertaken by the Department of Emergency Medicine of the complainant's medical management. The report has been provided to the Interim Vice President Quality and the local Quality Review Committee.

In addition, Fraser Health Authority commissioned an external review of this patient's management and the services provided by the Emergency Department. This review was chaired by G. Powell, MD FRCPC in Emergency Medicine, Director Emergency Medicine Foothills Hospital Calgary Alberta, and the team included A.S. Taylor, MD FRCPC and A. Mageau, RN.

Dr. Powell interviewed hospital staff including medical staff involved in this patient's care; he visited the department, and was provided with the necessary data to judge the patient care demands made upon the Emergency Department. The appropriate mechanisms were put in place to speak to the patients involved. They also did chart reviews and interviews of seven Emergency Department served patients who had self-reported through the information line.

It is my opinion that the internal and external reviews were complete and conclusions reached about the system issues valid.

Recommendation #7: Emergency Department Practices and Head Injury Management

My mandate does not allow access to patient records or to comment upon the care provided to individual patients. The care of individual patients was evaluated by the internal and external reviews. The conclusions drawn by the reviewers regarding the care of individual patients are protected under Section 51 of the *Evidence Act*.

Recommendation #8: Fraser Health Authority develop and implement the following policies in its acute care institutions

1. no-refusal transfer policy;
2. life and limb priority transfer policy;
3. diversion policy for Emergency Departments during periods of over capacity;
4. most responsible physician policy;
5. emergency physician handover policy;
6. pre-discharge review policy.

Recommendation #9: Implement guidelines for:

1. **the review of patients who are waiting for prolonged periods in the waiting room;**
2. **the follow- up of patients who leave the department without being seen or who self discharge against medical advice.**

Recommendation #10: Accelerate the Emergency re-development plan; evaluate the Emergency Department flow-through.

Recommendation #11: Train Emergency Department medical and nursing staff in the assessment, development and implementation of quality management tools

Recommendation #12: Adopt guidelines for management of:

1. **head injured patients;**
2. **intoxicated patients.**

Recommendation #13: Establish a neurology consultation service at Surrey Memorial Hospital to address clinical needs in the Emergency Department and nursing education requirements for in-patients.

Recommendation #14: Evaluate the needs of the population served by Fraser Health Authority for scheduled and emergency neurosurgical services and determine the limitations to providing emergency neurosurgical care at Royal Columbia Hospital and Surrey Memorial Hospital. Address these limitations so that acute neurosurgical interventions can be provided at both sites if required by the population.

Recommendation #15: Establish a functional, regional image transfer system and in the interim, provide computed tomographic and or magnetic resonance images to consulting neurologists or neurosurgeons at the time of patient referral.

B. Assessment of the Surrey Memorial Hospital's Quality Review relating to the specific patient complaints identified by the Minister of Health Services.

The Issue

Although Surrey Memorial Hospital has had a staff member charged with patient complaint management for many years, it was not until patients made their concerns known through the media that the hospital was aware of their concerns. The 1-877 toll-free line and the Fraser Health Authority website had been available since the creation of the Fraser Health Authority but had not been used for complaint reporting from the public prior the recent media events.

In response to a groundswell of public concern, Fraser Health Authority made available their toll free line as well as their website for the purposes of patient complaint reporting. In excess of 100 patients made their quality of care concerns known through this mechanism.

The Complaint Manager at Surrey Memorial Hospital and the administrative staff were directly involved in following up with all complainants in accordance with the Fraser Health Authority complaint and complement policy.

Other than written information provided by the Family Birthing Unit, instructions for accessing the Complaint Manager are not readily available to patients, families or the general public. There are no "comment boxes" or other devices seeking input from patients, families or members of the hospital community readily available in the facility.

Surrey Memorial Hospital and Fraser Health Authority Response

The existing complaint and complement management process was applied and worked well. Efforts to contact all complainants were made within days of the public or self-reports. Contact was made with the complainants and clarification of their concerns was achieved for the majority. All other calls received via the toll-free line were triaged appropriately.

All complaints registered through the toll-free line have been investigated and the patients contacted for clarification. A report has been completed and made available to the Interim Vice President of Quality.

Adequacy of the Complaint Management Process

The process is adequate and responded well to the demands. This is due to the skill of the complaint manager and the process provided by the existing policy.

Recommendations - Complaint Management Process

Recommendation #16: Continue and expand the role of the complaint manager in the acute care institutions and chronic sector facilities.

Recommendation #17: Provide better information and tools so that the patients, clients, families and members of the hospital and health authority community can access the complaint and compliment process more readily. Fraser Health should have a specifically designated complaint line and access for same by their website. Complaints and the health authority responses should be reported to the Board regularly.

C. Fraser Health Quality and Safety Organization

As mentioned previously, post-operative wound surveillance was reorganized with the development of Fraser Health Authority and the regionalization of infection control practitioner staff. Following regionalization, active post-operative wound surveillance was not maintained and regular reporting to programs was lost. Unfortunately, programs were not informed of these changes until the expected reports were noted to be missing.

During the first two years of Fraser Health Authority, significant effort was expended on the organization of the quality structures within this large and diverse health authority. The development of local Quality Review Committees, the Regional Quality Council, and the Board Quality Committee has all required significant effort and resources. Clinical decision support required for surveillance and quality monitoring and interpretation has focused on the broader health authority needs and reporting to the Board.

The development of a centralized office for policy development and implementation, while attempting to provide consistency and consensus has resulted in a lack of responsiveness to the providers who depend on these directional documents.

The changes that affect the front line have not gone unnoticed by practitioners or by individuals in the quality and risk management portfolio. This disconnection between the health authority organization and the needs of care teams is seen to be a weakness in the current organizational structure.

To address this disconnect, clinical teams and the quality and risk staff recommend augmenting and strengthening front-line quality monitoring and improvement. A plan for the necessary re-structuring of the quality and risk portfolio has been developed and tabled at the Fraser Health Authority executive. In conjunction with this re-organization, clinical decision support should be organized to provide the necessary measurement and interpretative capacity required for quality monitoring surveillance and improvement. Infection control should remain within the Quality and Risk Management portfolio.

Recommendation #18: Support the restructuring proposal for the quality and risk portfolio, including infection control and clinical decision support. Focus quality efforts and support on the clinical care teams and structure the required monitoring and evaluation systems.

Recommendation #19: Ensure that the HAMAC, the institutional MACs and the Quality Councils are provided with the necessary reports, information and data so that they can be held accountable for medical quality of care as required by the Health Authority Bylaws and the Health Authority Board.

D. Recommendations for Provincial Action Arising from this Review

The Province would benefit from a standardized approach to many issues raised by this review. The following are recommendations for which a timely coordinated approach would be of benefit to ensure province wide consistency.

(i) Develop a standardized surgical site and infection control surveillance and reporting program that addresses the continuum of care. Such a system requires the adoption of standardized definitions and audit tools, standardized criteria for wound culturing as well as inspection by medical and surgical staff, and the routine training and auditing for consistency in the application of definitions. Appropriately structured and resourced infection control services in the health authority's acute and subacute institutions are required.

(ii) Review of the prenatal and perinatal clinical record and the role of BC Reproductive Care Program in the development of post-natal tracking of birthing complications

(iii) Review of Emergency Department documentation to ensure that it accurately reflects the care provided to patients.

(iv) Develop and implement standards for:
   a. pre-discharge review of patients held in Emergency Departments;
   b. hand-off of patients at the end of shift (physician and nursing); and
   c. follow-up of patients who discharge against medical advice or leave without being evaluated.

(v) Hand washing: All institutions should put in place compliance auditing of hand-washing.

(vi) Surgical audits measuring compliance for:
   a. double-gloving in the situation of Caesarian section;
   b. administration of prophylactic antibiotics;
   c. operative site preparation; and
   d. instrument sterilization and reuse.

(vii) Post-operative instructions for all patients in hospital as part of a "keep yourself safe" policy, including wound healing and follow-up instructions.

(viii) In the context of improving patient safety and the quality of care, establish a Provincial Infection Control Committee for monitoring surgical site infections, urinary tract infections, line infections and facility cleanliness. Publish an annual nosocomial infection report based on the performance of all health authorities. This report should address the rates of surgical wound infections, line infections, urinary tract infections and facility cleanliness.

(ix) Create a system to inform authorities of the results of investigations and reviews so that they can:

   a. evaluate their internal systems; and
   b. adopt recommendations where internal processes are found lacking.

Appendix A – Interviews

The following individuals from Surrey Memorial Hospital and Fraser Health were interviewed:

Dr. David Matheson
Ms. Kathy Weir
Ms. Joanne Konnert
Ms. Louise Dixon
Ms. Pam McElheran
Dr. Richard Fuggy
Dr. Rene Chong-Sit
Dr. Keith Still
Dr. Duncan Criestar
Ms. Leslie Smith
Ms. Jan Radford
Ms. Colleen Harrs
Ms. Val Schalls
Dr. Pam Clark
Ms. Hazel Stack
Dr. Peter Hill

Reviewers Interviewed:

Dr. Elizabeth Bryce

Appendix B - Documents Reviewed

Patient documents and educational materials available through the Family Birthing Unit

The Fraser Health Response to Post-Operative Caesarean Wound Infections – November 2004

Client Liaisons and Complaint Management at Surrey Memorial Hospital – Draft Policy – August 12, 2004

Log of Concerns – November 19, 2004

Surrey Memorial Hospital Complaint Analysis Work Sheet (Anatomitized)

Surrey Memorial Hospital Program Area: Emergency Statistics

Surrey Memorial Hospital Emergency Department Guidelines for Quality Nursing and Outcome Monitoring, Quality Structure Sub-section

The Structure and Role of the Local Quality Review Committee – Surrey Memorial Hospital

Local Quality Review Committee Terms of Reference dated November 23, 2004

Quality Improvement and Risk Management Organizational Structure – November 19, 2004

Position Descriptions – Advisor, Risk Management System, Client Relations – March 2003

Roles and Responsibilities for Leadership and Accountability, Fraser Health – 2004

Management of Critical Incident Policy, Fraser Health Authority

Root Cause Analysis Flow Sheet, Fraser Health Authority

A Request for Quality Review under Section 51 under the *Evidence Act*, Fraser Health Authority

Recommendations from Internal and External Reviews (Public)

- The Internal Review - Validation of Infections
- External Review – Validation of Infections
- External Review – Infection Control – Bryce
- External Review – Obstetrical Management – Frinton
- External Review – Emergency Department – Powell

Appendix C – Terms of Reference

Minister of Health Services Requested Review: Patient Incidents at Surrey Memorial Hospital

Reviewer: Dr. Doug Cochrane, Chair of BC's Patient Safety Task Force and VP Medical Affairs, Quality, Safety and Risk Management for the Provincial Health Services Authority.

A. Quality Review

1. Identify the core components of a quality review.
2. Review process undertaken by the Fraser Health Authority in the conduct of their review of the patient care complaints to ensure that a comprehensive analysis has been performed and that these core elements have been completed which include, but are not limited to:

   - structure of incident review process;
   - involvement of internal and external experts;
   - patient/family interviews;
   - documentation of review;
   - reporting accountability (e.g., Medical Advisory Committee, senior management, Board); and
   - communication of lessons learned.

B. Assessment of Surrey Memorial Hospital's Quality Review

1. Evaluation of the quality review at Surrey Memorial Hospital relating to the specific patient complaints identified by the Minister of Health Services.

C. Review of the Fraser Health Authority Quality of Care Monitoring and Reporting System

1. Define a framework for quality of care monitoring and accountability for institutions and health authorities.
2. Review the structures and processes that the Fraser Health Authority uses to assess the quality of clinical care and mitigate patient risk. This will include but is not limited to the quality assurance and risk management structures and processes relating to medical staff, nursing, programs, departments and the Health Authority Medical Advisory Committee. To be addressed in the review is the process for:

- physician credentialing and review;
- medical department quality assurance and outcome monitoring including clinical audits, mortality and morbidity review, complaint management, quality improvement initiatives;
- program quality and outcome monitoring and risk identification;
- nursing quality assurance;
- Health Authority Medical Advisory Committee quality structures;
- executive accountability; and
- indicator reporting.

D. Report to the Minister of Health Services

Dr. Cochrane will report to the Minister of Health Services no later than December 20, 2004 on all components of the terms of reference including recommendations applicable to all health authorities.